CHRISTOPHER WAYNE LESTER
MADISON MEDICAL GROUP
RECORDS
14-P

Charleston Area Medical Center
Charleston, WV

CAMC Outpatient Services
Pt. Name: LESTER, CHRISTOPHER W
Medical Record #: 0000301467
Billing #: 1203788565
Pt Phone #:(304)369-2395
Pt SSN #: [redacted]8340

Location: GED
Req. Physician: BAILEY, T.
DOB: 12/23/1971 Age: 28 Sex: M
Nuclear Medicine Lab: 348-7454
CAMC Lab: 348-4190

Order#: 15100852
Date&Time Ordered: 03/10/00 08:05
Copy to:

FINAL

CHEMISTRY BLOOD PROFILES

TEST NAME	FLAG	RESULT	NORMAL RNG	UNITS	LOC
SPECIMEN PST COLLECTED 03/10/00 08:20 BY ACAMP RECEIVED 03/10/00 08:37 BY ACAMP					
BASIC METABOLIC PANEL					
SODIUM		137	136-146	mmol/L	
POTASSIUM		3.9	3.5-5.1	mmol/L	
CHLORIDE		103	98-110	mmol/L	
CARBON DIOXIDE		25	23-29	mmol/L	
GLUCOSE		106	70-108	mg/dL	
BUN		14	7-18	mg/dL	
CREATININE		0.7	0.6-1.4	mg/dL	

HEMATOLOGY BLOOD STUDIES

TEST NAME	FLAG	RESULT	NORMAL RNG	UNITS	LOC
SPECIMEN LAV COLLECTED 03/10/00 08:20 BY ACAMP RECEIVED 03/10/00 08:37 BY ACAMP					
COMPLETE BLOOD COUNT					
WBC		8.4	4.8-10.8	X/cu mm	
RBC		5.81	4.40-6.20	M/cu mm	
HEMOGLOBIN	H	17.1	14.0-16.0	g/dL	
HEMATOCRIT		49.4	41.0-53.0	% Volume	
MCV		85	80-100	fL	
MCH		29.5	27.0-32.0	pg	
MCHC		34.7	32.0-36.0	%	
RDW		12.4	12.0-15.0	%	
PLATELET COUNT		261	140-450	X/cu mm	
MPV		8.2	6.6-9.3	fL	
LYMPHOCYTES		17.6	20.0-35.0	%	
MONOCYTES		4.2	0.0-8.0	%	
NEUTROPHILS		76.8	50.0-78.0	%	
EOSINOPHILS		0.8	0.0-4.0	%	
BASOPHILS		0.6	0.0-2.0	%	

LOC (Performing location) indicates test performed at location different from patient location: G = Gen Div; M = Mem Div; W =
Key For Flags: L-Low, H-High, A-Alert, AB-Abnormal, %D-Delta, aD-Absolute Delta

General Division
501 Morris Street
Charleston, WV 25301

Memorial Division
3200 MacCorkle Avenue
Charleston, WV 25304

Womens and Children
800 Pennsylvania Avenue
Charleston, WV 25302

Charleston Area Medical Center
Charleston, WV

CAMC Outpatient Services
Pt. Name: LESTER, CHRISTOPHER W
Medical Record #: 0000301467
Billing #: 1203788565
Pt Phone #:(304)369-2395
Pt SSN #: [redacted]0340

Location: GKD
Req. Physician: BAILEY, T
DOB: 12/23/1971 Age: 28 Sex: M
Nuclear Medicine Lab: 348-7454
CAMC Lab: 348-4190

MISCELLANEOUS BLOOD CHEMISTRIES

TEST NAME	FLAG	RESULT	NORMAL RNG	UNITS	LOC
SPECIMEN PST COLLECTED 03/10/00 08:20 BY ACAMP RECEIVED 03/10/00 08:37 BY ACAMP					
BLOOD CHEMISTRIES					
AMYLASE		31	4-88	U/L	

LOC (Performing location) indicates test performed at location different from patient location: G = Gen Div; M = Mem Div; W =
Key For Flags: L-Low, H-High, A-Alert, AB-Abnormal, %D-Delta, aD-Absolute Delta

General Division
501 Morris Street
Charleston, WV 25301

Memorial Division
3200 MacCorkle Avenue
Charleston, WV 25304

Womens and Children
800 Pennsylvania Avenue
Charleston, WV 25302

Charleston Area Medical Center
Charleston, WV

CAMC Outpatient Services
Pt. Name: LESTER, CHRISTOPHER W
Medical Record #: 0000301467
Billing #: 1203788565
Pt Phone #: (304)369-2395
Pt SSN #: [redacted]3340

Location: GED
Req. Physician: BAILEY, T:
DOB: 12/23/1971 Age: 28 Sex: M
Nuclear Medicine Lab: 348-7454
CAMC Lab: 348-4190

Order#: 15101195
Date&Time Ordered: 03/10/00 10:52
Copy to:

FINAL

URINALYSIS

TEST NAME	FLAG	RESULT	NORMAL RNG	UNITS	LOC
SPECIMEN RCV COLLECTED 03/10/00 10:52 BY RECEIVED 03/10/00 11:12 BY CMF					
URINALYSIS					
COLOR		YELLOW	STRAW-AMBER		
CLARITY		CLEAR	CLEAR-CLOUD		
SPECIFIC GRAVITY		1.010	1.010-1.020		
PH		6.0	5.0-7.5		
PROTEIN		NEGATIVE	NEGATIVE	mg/dL	
GLUCOSE		NEGATIVE	NEGATIVE	mg/dL	
KETONES		NEGATIVE	NEGATIVE	mg/dL	
BILIRUBIN		NEGATIVE	NEGATIVE		
BLOOD		NEGATIVE	NEGATIVE		
NITRITE		NEGATIVE	NEGATIVE		
UROBILINOGEN		0.2	<=1	EU/dL	
LEUKOCYTE ESTERASE		NEGATIVE	NEGATIVE		
MUCUS		SLIGHT	NONE SEEN	/hpf	
AMURATE CRYSTALS		SLIGHT	NONE SEEN	/hpf	
BACTERIA		FEW	FEW	/hpf	

LOC (Performing location) indicates test performed at location different from patient location: G = Gen Div; M = Mem Div; W =
Key For Flags: L-Low, H-High, A-Alert, AB-Abnormal, %D-Delta, aD-Absolute Delta
Printed: 03/11/2000 03:06 CLINICAL LABORATORY PAGE: 1 of 1

General Division
501 Morris Street
Charleston, WV 25301

Memorial Division
3200 MacCorkle Avenue
Charleston, WV 25304

Womens and Children
800 Pennsylvania Avenue
Charleston, WV 25302

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Workers Comp Attn: Sam Suppa

FROM: Dr. JM. Snyder / Debbi

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 3

DATE: 5/1/00

ADDITIONAL COMMENTS:

THANK YOU.

FAXED 5/1/00 DH

MADISON MEDICAL, PLLC
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170

WV Worker's Compensation
P. O. Box 431
Charleston, WV 25322-0431

To Whom It May Concern:

Please authorize the purchase of the following medications for this patient for the treatment of his/her compensable injury.

Sincerely, John Mark Snyder DO/DH

Patient: Christopher Lester

SSN: [redacted] 3340

DOI: 3/10/2000

RX'S Vicoden ES tpo q 4°-6° prn

For the treatment of : 847.0, 847.1, 847.2, 959.01

FAXED 5/1/00 DA

May 1, 2000

Worker's Compensation
P. O. Box 3151
Charleston, WV

RE: Christopher Lester
SSN: [redacted] 3340
DOI 3/10/200
Claim No. 2000046841

To Whom It May Concern,

I saw Christopher on 4/26/00 and prescribed Vicodin ES for pain and we received a call back from the pharmacy that this needs approval. I find this interesting in that he is still in acute phase of his pain and does need narcotic pain relief at this point and time. I would appreciate speedy approval of this.

Sincerely,

John M. Snyder, D. O.
JMS:bw

FAXED 5/1/00 DH

500688.015.0535

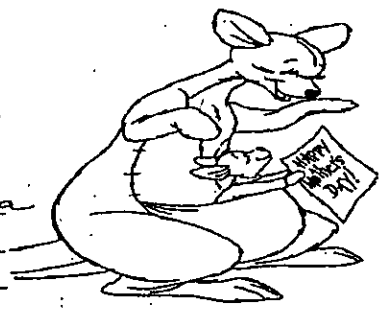
* * * Transmission Result Report (MemoryTX) (May. 1. 2000 4:27PM) * * *

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
6461	Memory TX	13049265486	P. 3	OK	

Reason for error
E.1) Hang up or line fail
E.2) Busy
E.3) No answer
E.4) No facsimile connection

MADISON MEDICAL, P.L.L.C.
705 MADISON AVENUE
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET



TO: Workers Comp Attn: SamSuppa
FROM: D.J.M. Snyder / Debi
RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 3
DATE: 5/1/00
ADDITIONAL COMMENTS:

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

FOR DIVISION USE ONLY
Claims Manager Cheryl Armes
Trucking/Agr & Food Proc
Claimant's County BOONE

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. 2000046841 SS No. [redacted]-3340
Emp. Fisk No. 98001651 DOI 03/10/2000
2. Current Telephone No. 304-369-6657

Claimant's Name and Address

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature _____ Date _____

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 04 / 20 / 00 (Month Day Year)
2. Date of next appointment 04 / 26 / 00 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☒ Yes ☒ No If Yes, please advise as to how the claimant came under your care. Referral

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☐ Consultation ☐ Evaluation ☒ Treatment PT

4. Diagnosis (ICD9-CM) code and description
847.0, 847.1, 847.2
959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
Conservative Treatment
maintain Physical Therapy

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☒ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☒ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work 05 / 22 / 00 Full-time Work ____

10. If the claimant has reached **maximum medical improvement**, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form **WC-219a, Notice of Maximum Medical Improvement.**

11. Physician's Name, Address & Telephone No.
~~CHARLESTON AREA MEDICAL CENTER~~
~~501 MORRIS STREET~~
~~CHARLESTON, WV 25326~~
J. Mark Snyder
705 Madison Ave
Madison WV
25130
Phone: 304 ~~340-3322~~ 369-5170
FEIN ~~550526150~~ 550626546

12. _____ Physician's Signature
04/26/00 Date

500688.015.0537

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

WC-219 Rev. 9-94

FOR DIVISION USE ONLY
Claims Manager Cheryl Armes
Trucking/Agr & Food Proc
Claimant's County BOONE

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. 2000046841 SS No. [redacted]340
Emp. Fisk No. 98001651 DOI 03/10/2000
2. Current Telephone No. 304-369-6657

Claimant's Name and Address:
CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address:
D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

3. *Please mark any needed changes in your address as printed above.*

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature _____ Date _____

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 04/26/00 (Month Day Year)
2. Date of next appointment 05/01/00 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care. _____

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☐ Consultation ☐ Evaluation ☒ Treatment: PT

4. Diagnosis (ICD9-CM) code and description
847.0, 847.1, 847.2
959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
maintain conservative treatment

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☒ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☒ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work 06/05/00 Full-time Work ____

10. If the claimant has reached **maximum medical improvement**, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form **WC-219a, Notice of Maximum Medical Improvement.**

11. Physician's Name, Address & Telephone No.
J. Marie Snyder, DO.
MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

Phone: 304-369-5170

FEIN 550664546

12. Physician's Signature

04/28/00
Date

500688.015.0538

MADISON MEDICAL, P.L.L.C.
705 MADISON AVE:
MADISON, WV 25130
PHONE# (304)369-5170 FAX# (304)369-1742

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: Eye & Ear Clinic
DOCTOR

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
J Mark Snyder DO

THE COMPLETE RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESSES AND/OR TREATMENTS DURING THE PERIOD FROM

FAXED

all TO _____

NAME: Christopher Lester DATE: 4-7-00

ADDRESS: PO Box 1113
Danville WV 25053

BIRTHDATE: 12-23-71 SSN# [redacted]-3340

SIGNATURE: Christopher Lester
(IF RELATIVE STATE RELATION)

WITNESS: Paula Baldwin

THIS RELEASE AND AUTHORIZATION SHALL BE VALID FOR ONE YEAR FROM ITS DATE OF SIGNATURE UNLESS TERMINATED IN WRITING BEFORE THAT DATE.

*If a fee is required for records please pre-bill. The physicians office will not be responsible for any fees incurred.

extt/01-01-96/*6 ** /ENDOR COPY ** 1024458

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

April 19, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]-3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - NOTICE OF BENEFITS

I have received medical evidence which indicates you continue to be disabled from working from 04/04/2000 through 05/07/2000.

If it is later determined you are not entitled to benefits or expenses, the Division may recover these overpayments.

If medical evidence showing continued disability is not received, your claim may close for temporary total disability benefits on 06/21/2000.

If you have any questions or concerns, you may reach me at 304-926-5375.

Workers' Compensation Division
By: Cheryl Armes
Claims Representative 2

CC: D & M TRUCKING CORPORATION INC
CHARLESTON AREA MEDICAL CENTER
VASS VOCATIONAL SERVICES

chtp/5-4-98/*6 ** VENDOR COPY ** 1024458

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

April 19, 2000

MADISON MEDICAL PLLC
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Re: Claim 2000046841
S.S.N. [redacted]3340
D.O.I. 03/10/2000

PLEASE READ CAREFULLY - CHANGE OF TREATING PHYSICIAN

We have received a request dated, 4/7/2000 from CLAIMANT to recognize J. MARK SNYDER D. O. as the treating physician of record in your claim. Your transfer from CHARLESTON AREA MEDICAL CENTER has been noted.

This letter does not authorize payment for medical expenses. Your new physician should send us an initial evaluation report. This report should include his/her recommendations for treatment and a request for services that require prior approval. If the Division determines the treatment is medically necessary and related to the condition for which your claim was filed, we will authorize the treatment and payment will be issued for the initial evaluation and other services. However, if your current condition is not due to the compensable injury or if the report fails to show the need for further treatment, the cost for such services by the physician will be your responsibility.

If you have any questions or concerns, you may reach me at 304-926-5375.

Workers' Compensation Division
BY: Cheryl Armes
Claims Representative 2

CC: D & M TRUCKING CORPORATION INC
CHARLESTON AREA MEDICAL CENTER
VASS VOCATIONAL SERVICES

Attending Physician' Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

DIVISION USE ONLY
Claims Manager Cheryl Armes
Trucking/Agr & Food Proc
Claimant's County BOONE

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. 2000046841 SS No. [redacted]-3340
Emp. Fisk No. 98001651 DOI 03/10/2000

2. Current Telephone No. 304-369-6657

Claimant's Name and Address

CHRISTOPHER W LESTER SR
P.O. BOX 1113
DANVILLE, WV 25053

Employer's Name and Address

D & M TRUCKING CORPORATION
502 BOB VINES RD
GHENT, WV 25843

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature _____ Date _____

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 04 07 00 (Month Day Year)
2. Date of next appointment 04 20 00 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☒ Yes ☐ No If Yes, please advise as to how the claimant came under your care. _____

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☐ Consultation ☐ Evaluation ☒ Treatment Physical Therapy

4. Diagnosis (ICD9-CM) code and description
847.0, 847.1, 847.2
959.01

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
Conservative treatment
await results of physical therapy

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☒ No If Yes, please explain condition and how it has affected recovery.

7. Will claimant need rehabilitation services? ☐ Yes ☒ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work 05 08 00 Full-time Work ____

10. If the claimant has **reached maximum medical improvement**, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form **WC-219a, Notice of Maximum Medical Improvement.**

11. Physician's Name, Address & Telephone No.
~~CHARLESTON AREA MEDICAL CENTER~~
~~501 MORRIS STREET~~
~~CHARLESTON, WV 25326~~
J. Mark Snyder
705 Madison Ave
Madison WV 25130
Phone: 304-~~348-3323~~ 369-5170
FEIN ~~550526150~~ 550664546

12. _____ Physician's Signature
4-17-00 Date

500688.015.0542

Charleston Area Medical Center
Charleston, West Virginia

* 7 3 9 2 *

USE SPACE BELOW FOR IDENTIFICATION IF NECESSARY

NAME ROOM NO.

LESTER ,CHRISTOPHER W MR: 0000301467
BAILEY, T. DAVID PN: 1203788565
ADM 03/10/00 GED DOB [redacted]/1971

EMERGENCY DEPARTMENT:

- [X] GENERAL DIVISION — 304) 348-7498
- [ ] MEMORIAL DIVISION – (304) 348-4170
- [ ] WOMEN & CHILDREN'S HOSPITAL – (304) 348-2550

EMERGENCY DEPARTMENT AFTERCARE INSTRUCTIONS

- [ ] Keep dressing clean and dry
- [ ] Keep injured part elevated as much as possible for _____ days
- [ ] Ice (intermittently) to injured area for _____ minutes _____ times a day.
- [ ] Heat (intermittently) to injured area for _____ minutes _____ times a day.
- [ ] Aspirin/Tylenol for pain or fever
- [ ] You MAY [X] MAY NOT Return to Work or School Today
- [ ] No weight bearing for _____ days
- [ ] Re-Wrap Ace Bandage if too loose or too tight.
- [ ] Crutches as advised (They are sold to you)
- [X] Take prescription(s) as directed
- [ ] You have been started on Tetanus Immunization Series today. Please complete the series with your private M.D. or Clinic.
  1. 1–2 Months from today — 1/2 cc Tetanus Toxoid
  2. 6 Months—1 Year from today —1/2 cc Tetanus Toxoid

  This will complete your Tetanus Immunization.
- [ ] Be on the alert for signs of possible infection.

Increased Pain	Fever
Redness	Warmth
Swelling	Red Streaks

CONTACT YOUR PHYSICIAN IMMEDIATELY IF THESE OCCUR

Your EKG will be reviewed and if any significant abnormalities are discovered, you may be recalled to the Emergency Department.

Your X-Ray will be interpreted by a radiologist and if any abnormalities are discovered, you may be recalled to the Emergency Department.

OTHER SPECIFIC INSTRUCTIONS:

CALL TO ARRANGE AN APPOINTMENT AT:

- [ ] Children's Medicine Center 348-2525 IN _____ DAYS
- [ ] Women's Medicine Center 348-2427 IN _____ DAYS
- [ ] Medicine Clinic/ Surgery Clinic (Memorial) 348-5530 IN _____ DAYS
- [ ] Surgery Clinic (General) 348-6355 IN _____ DAYS
- [ ] Other: Caro Health IN _____ DAYS

- [ ] FOR FOLLOW-UP CARE, PHONE: 348-1000
  ADDRESS: 1411-C Maccorkle Ave
  (Call sooner if you feel it is necessary)
- [X] THE MEDICATION RECEIVED IN THE EMERGENCY DEPARTMENT MAY CAUSE DROWSINESS. YOU ARE WARNED AGAINST DRIVING OR OPERATING MACHINERY FOR: (+ Prescribed)
  [ ] 6 HOURS. [X] 12 HOURS [ ] _____ HOURS

OTHER INSTRUCTIONS:

1. Discharge home
2. See head injury sheet for further instructions
3. Return for any problems to Emergency Dept.

IMPORTANT NOTICE:
TREATMENT IN THE EMERGENCY DEPARTMENT IS OFFERED AS EMERGENCY FIRST CARE ONLY. FOLLOW-UP TREATMENT BY A PHYSICIAN MAY BE IMPORTANT FOR YOUR SAFETY. YOU ARE URGED TO FOLLOW CAREFULLY THE INSTRUCTIONS GIVEN ON THIS SHEET.

Date: 3-10-00 Patient's Signature: [signature]

Patient's Name: _____ Witness: [signature]

White Copy – Chart • Yellow Copy – Patient

17-7392 ITEM 1280 **EMERGENCY DEPARTMENT AFTER CARE INSTRUCTIONS** MR Rev. 8-99

CORPORATE HEALTH SERVICES
AFFILIATED WITH Charleston Area Medical Center

NAME: Christopher
SOCIAL SECURITY #: [redacted] 3240
EMPLOYER: DTM Trucking
DATE: 3-27-00

348 6730
Bailey
Asaad
Funk

RETURN TO WORK GUIDELINES

If the Employer is unable to provide the worker with the limited duty indicated, the worker should be placed off duty until the next scheduled physician's appointment.

DATE: 3 27 00 DATE OF INJURY: 3-16-00

WORK STATUS:

1. Full Duty _____
2. Limited Duty _____
3. Unable to Work _____

NEXT PHYSICIAN APPOINTMENT: 1 wk 4/3 9:30

RELEASE FROM TREATMENT: _____

Diagnosis:
1. (L) Shoulder Strain
2. Cervical Strain
3. Closed Head Injury

COMMENTS: Out PT

TIME IN: _____
TIME OUT: 11:10

PHYSICIAN'S SIGNATURE

March 27, 2000
DATE

Occupational Medicine • (304) 348-1000 • 1418C MacCorkle Ave., SW • Charleston, WV 25303

CHS-0002 Rev. 1-99

500688.015.0545

CORPORATE HEALTH SERVICES
AFFILIATED WITH Charleston Area Medical Center

NAME: Chris Lester
SOCIAL SECURITY #: [redacted] 3340
EMPLOYER: D & M Trucking Corp Inc
DATE: 3-22-00

RETURN TO WORK GUIDELINES

If the Employer is unable to provide the worker with the limited duty indicated, the worker should be placed off duty until the next scheduled physician's appointment.

DATE: 3-22-00 DATE OF INJURY: 3-10-00

WORK STATUS:

1. Full Duty ~~Truck Driver~~
2. Limited Duty _____
3. Unable to Work 3-22-00

NEXT PHYSICIAN APPOINTMENT: Mon. @ 9:00 am

RELEASE FROM TREATMENT: _____

Diagnosis:
1. Closed Head Injury, Concussion, Cervical Strain
2. (D) Shoulder Sprain
3. Chest wall Contusion.

COMMENTS: _____

TIME IN: 2:20pm
TIME OUT: 15:30

PHYSICIAN'S SIGNATURE

March 22, 2000
DATE

Occupational Medicine • (304) 348-1000 • 1418C MacCorkle Ave., SW • Charleston, WV 25303

CHS-0002 Rev. 1-99

500688.015.0546

Charleston Area Medical Center
Charleston, West Virginia

* 7 3 9 2 *

6349220

LESTER ,CHRISTOPHER W MR: 0000301467
KWEI, LEON S. PN: 1203807506
ADM 03/13/00 GED DOB [redacted]1971

USE SPACE BELOW FOR IDENTIFICATION IF NECESSARY

NAME ROOM NO. G Back Hall

EMERGENCY DEPARTMENT:

- [X] GENERAL DIVISION — 304) 348-7498
- [ ] MEMORIAL DIVISION – (304) 348-4170
- [ ] WOMEN & CHILDREN'S HOSPITAL – (304) 348-2550

EMERGENCY DEPARTMENT AFTERCARE INSTRUCTIONS

- [ ] Keep dressing clean and dry
- [ ] Keep injured part elevated as much as possible for _____ days
- [ ] Ice (intermittently) to injured area for _____ minutes _____ times a day.
- [ ] Heat (intermittently) to injured area for _____ minutes _____ times a day.
- [ ] Aspirin/Tylenol for pain or fever
- [ ] You MAY [ ] MAY NOT Return to Work or School Today
- [ ] No weight bearing for _____ days
- [ ] Re-Wrap Ace Bandage if too loose or too tight.
- [ ] Crutches as advised (They are sold to you)
- [X] Take prescription(s) as directed Vicodin
- [ ] You have been started on Tetanus Immunization Series today. Please complete the series with your private M.D. or Clinic.
  1. 1–2 Months from today — 1/2 cc Tetanus Toxoid
  2. 6 Months—1 Year from today —1/2 cc Tetanus Toxoid

  This will complete your Tetanus Immunization.
- [ ] Be on the alert for signs of possible infection.

Increased Pain	Fever
Redness	Warmth
Swelling	Red Streaks

CONTACT YOUR PHYSICIAN IMMEDIATELY IF THESE OCCUR

Your EKG will be reviewed and if any significant abnormalities are discovered, you may be recalled to the Emergency Department.

Your X-Ray will be interpreted by a radiologist and if any abnormalities are discovered, you may be recalled to the Emergency Department.

OTHER SPECIFIC INSTRUCTIONS:

CALL TO ARRANGE AN APPOINTMENT AT:

[ ] Children's Medicine Center	348-2525	IN _____	DAYS
[ ] Women's Medicine Center	348-2427	IN _____	DAYS
[ ] Medicine Clinic/ Surgery Clinic (Memorial)	348-5530	IN _____	DAYS
[ ] Surgery Clinic (General)	348-6355	IN _____	DAYS
[ ] Other: _____		IN _____	DAYS

- [ ] FOR FOLLOW-UP CARE, PHONE: _____
  ADDRESS: _____
  (Call sooner if you feel it is necessary)
- [ ] THE MEDICATION RECEIVED IN THE EMERGENCY DEPARTMENT MAY CAUSE DROWSINESS. YOU ARE WARNED AGAINST DRIVING OR OPERATING MACHINERY FOR:
  [ ] 6 HOURS. [ ] 12 HOURS [ ] _____ HOURS

OTHER INSTRUCTIONS: Discharge to home, Return for any problems, Wear Sling, Follow-up with Corporate Health as directed (8am tomorrow - 348-1000), Follow-up with Dr. Phillips (EN (353-0400), Follow-up with Dr. Zaka. b Cor (346-0439), and with Dr. K. Wright (340-7345) at Med Rehab

IMPORTANT NOTICE:
TREATMENT IN THE EMERGENCY DEPARTMENT IS OFFERED AS EMERGENCY FIRST CARE ONLY. FOLLOW-UP TREATMENT BY A PHYSICIAN MAY BE IMPORTANT FOR YOUR SAFETY. YOU ARE URGED TO FOLLOW CAREFULLY THE INSTRUCTIONS GIVEN ON THIS SHEET.

Date: 3-13-00

Patient's Signature: [signature]

Patient's Name: _____

Witness: [signature] RN

CAT SCAN 3/13

White Copy – Chart • Yellow Copy – Patient

17-7392 ITEM 1280

EMERGENCY DEPARTMENT AFTER CARE INSTRUCTIONS

MR Rev. 8-99

500688.015.0547

03/14/00 TUE 08:59 FAX 304 3726 PATIENT ACCTS. 008

[redacted] Ev: T DAVID 03/10/00 GED PW [redacted] 1971 For Division Use Only

Workers' Compensation Divisio
Report of Occupational Injury
Prior to Completing this Form you must
Read the instructions on the Back of this Form

Claim Number: _____ Team Assigned: _____

WC-123 Rev. 1/98

Section I: Injured Worker Section - All Information Must Be Completed:

1. Name: Last Lester Sr. First Christopher M W
2. Social Security Number: 233-15-3346
3. Injury / Last Exposure Date: 3/10/00 Time: 5:30 AM PM
4. Address: P.O Box 1113
   City: Danville State: WV Zip Code: 25053
   County: Boone
5. Telephone: (304) 369-6657 Male Female
6. Date of Birth: 12/23/71 Marital Status: Married
7. Time You Began Work on Date of Injury: 5:00 AM PM
8. Stopped Work for Injury: Date ___/___/___ Time ___:___ AM PM
9. Date Employer Was Notified of Injury: 3/10/00
10. Who Was Notified of Injury: Jerry Phone: (304) 687-2486
11. Date First Went to Doctor / Hospital for this Injury: 3/10/00
12. Name of Doctor / Hospital: CAMC General

13. How Did Injury Occur? (Specify the cause, what you were doing, and Doing My Pre-trip inspection Was Checking the oil in My truck & the hood Knocked Me off.
14. Job Title / Description: Truck Driver
15. Did Injury Occur on Employer's Property? Yes No If No, Where? _____
16. Employer Name and Address: D&M Trucking
17. Supervisor's Name: Mark Cobb Phone: 304) 255-6826
18. List Name(s) and Phone Number of Witness(es) to the Accident (Attach List for More):
    Name: _____ Phone #: (___) ___ - ____
19. List the Name and Phone Number for any other employers for whom you are currently working? (Attach List for More) _____
20. If you have had any previous accidents or conditions affecting the same body part, give dates and details. (Attach List for More): [redacted] 7-10

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically W. Va. Code §23-4-19 provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize the Division and designated agents to examine all hospital and medical records and have verbal discussions with physicians, on any medical information pertaining to this injury and or any condition for which I have previously received medical attention. I acknowledge the provisions of W. Va. Code §23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative. Signature: _____ Date: ___/___/___

Section II: Attending Physician Section - All Information Must Be Completed:

1. WCD Vendor Number: 1081032
2. FEIN or SSN: 550526150
3. Name of Physician / Hospital: David Bailey
4. Address: P O Box 3329
   City: Chas State: WV Zip Code: 25325
5. Phone: 304 348 6730
6. Date You Were First Consulted For This Condition: 3/10/00
7. Is Condition a Result of (Check One) Occupational Injury? X
   Occupational Disease? ☐ Nonoccupational Condition? ☐
8. Nature, Body Part and Type of Injury (e.g. Sprained back due to over exertion): CHI Blunt Ext Cervical Thoracic Lumbar Strain
9. Diagnosis Code(s) (ICD9-CM) in Order of Severity: 95901 8470 8471 8472
10. Date claimant stopped work due to this condition: 3/10/00

11. Did this injury aggravate a chronic or prior injury/disease? Yes No If Yes, Explain: _____
12. Disability Period: ☐ Less than 4 days ☐ 2 Weeks ☐ Over 4 Weeks ☒ 1 Week ☐ 3 Weeks
13. Date Claimant Was (Will Be) Able to Return to Work: ___/___/___
14. Will claimant need Physical or Vocational Rehabilitation Services? Yes No Unkn
15. Describe rehabilitation needs: _____
16. Can Claimant return to modified work? Yes No If Yes, what restrictions? _____
17. If claimant was hospitalized, where? _____
18. Name and Address of Physician Referred to: Corporate Health

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement or withhold a material fact or statement respecting any information requested by the Division. By signing this form, I acknowledge the provisions of W. Va. Code §23-4-19 which provides for severe criminal penalties for the knowing and with fraudulent intent to aid and abet anyone in securing or attempting to secure benefits to which he or she is not entitled. Also, by signing this form, I acknowledge that any office notes/test results should be immediately sent to the Division.

Signature: _____ Date: 3/10/00

Section III: Employer Section - All Information Must Be Completed:

Employer sign here as acknowledgment of receipt of Sections I and II: _____ Date: _____

1. WCD Policy Number: _ _ _ _ _ _ _ - _ _ _
2. Industrial Code: _ _ _ _ Occupation (DOT) Code: _ _ _
3. FEIN or SSN: _____ Phone: (___) ___ - ____
4. Name of Employer as Listed with WCD: _____
5. Address to Send Claim Related Mail: _____
   City: _____ State: _____ Zip Code: _____
6. TPA Name & Phone, if applicable: _____
7. Employee is: ☐ Owner/Part Owner ☐ Full Time ☐ Part Time ☐ Officer ☐ Volunteer
8. If owner/part owner/officer, are wages included on wage reports? Yes No
9. Date employee was first employed by you: ___/___/___
10. Time at present job: _____ Years _____ Months

11. Date Claimant Returned to Work: ___/___/___
12. If returned to work, is it alternate or modified work? Yes No If Yes, indicate wages:
    Hourly rate: _____ Hours per week: _____
13. Daily rate of pay on the date of injury? $ _____
14. If part-time, Hourly rate: _____ Hours per week (25 or less): _____
15. Did injury occur at address listed in question 5? Yes No If No, Where? _____
    State: _____ County: _____ Zip Code: _____
16. Do you disagree with any information provided above, or do you have any reason to question this injury? Yes No If Yes, you must attach a specific explanation to this form.
17. Was an incident report completed? Yes No

CHARLESTON AREA MEDICAL CENTER

Department of Medical Imaging
GENERAL DIVISION
501 Morris Street
Charleston, WV 25301
(304) 348-6044

NAME: LESTER, CHRISTOPHER W
MRN:00301467
DOB: [redacted]/1971 00:00
Patient type: E
Requesting Service: GEN EMERGENCY DEPARTMENT
PT. NUMBER: 1203788565

PT. LOCATION:
SEX:M
Req. Phys: BAILEY, DAVID

Order: 1119361 Result: 930795 Addendum: 0

Procedure Completed Date: 03/10/2000

Reason: C 5 FELL UNABLE TO CLEAR

CT CERVICAL SPINE W/O CONTRAST

HISTORY: Recent fall.

3mm interval scans from the upper aspect of C5 through bottom aspect of T1 is performed with sagittal and coronal reconstructions. There is no acute fracture, subluxation or dislocation.

IMPRESSION:

No evidence of acute fracture or subluxation.

Dictated by: MARY H. MCJUNKIN, M.D. Job 1324 3-10-2000 1016 hours
Verified by: MARY H. MCJUNKIN, M.D. 03/10/2000 14:21

Trans: LAURA J. ODELL 03/10/2000 12:55

Technologist:RICHARD L. COOPER

RADIOLOGY REPORT

CHARLESTON AREA MEDICAL CENTER

Department of Medical Imaging
GENERAL DIVISION
501 Morris Street
Charleston, WV 25301
(304) 348-6044

NAME: LESTER, CHRISTOPHER W
MRN:00301467 PT. LOCATION:
DOB: [redacted]/1971 00:00 SEX:M
Patient type: E Req. Phys: BAILEY, DAVID
Requesting Service: GEN EMERGENCY DEPARTMENT
PT. NUMBER: 1203788565

Order: 1119241 Result: 930851 Addendum: 0

Procedure Completed Date: 03/10/2000

Reason: C5 FELL QUES LOC RT SIDED HASHOULDER RIB PAIN

CERVICAL SPINE ROUTINE

C6 and C7, as well as the C7-T1 relationship are not well visualized in the lateral projection. These areas appear within normal limits on the AP projections. Evaluation of this area by CT is recommended. The balance of the cervical spine is entirely within normal limits.

Dictated by: JAMES T. SMITH, M.D. job 1414 3 -10-2000 1156 hours
Verified by: JAMES T. SMITH, M.D. 03/10/2000 14:59

Trans: LAURA J. ODELL 03/10/2000 13:53

Technologist:LISA M. KELLY

RADIOLOGY REPORT

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner

West Virginia Bureau of Employment Programs
• Job Service/Job Training Programs • Labor Market Information
• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

RECEIVED
APR 06 2000
CUSTOMER SERVICE

CHANGE OF DOCTORS

CLAIMANT'S NAME: Christopher W. Lester Sr.

CLAIMANT'S NUMBER: _____

SOCIAL SECURITY NUMBER: [redacted]3340

DATE OF INJURY: 3-10-00

I am requesting to change doctors. I am presently seeing...

Dr. Bailey (Corporate Health)

I am requesting to see...

Dr. Snyder (at Madison Medical Group)

Address of requested doctor...

705 Madison Ave.
Madison, WV

My reason is...

She left the firm & Dr. Snyder is already my doctor. Also I have been to Corp. Health 5 times and been seen by 3 Different Doctors.

I have checked with the requested doctor to see if he will take me as a patient... Yes ✓ No__

CLAIMANT'S SIGNATURE: Christopher W. Lester Sr.

DATE: 4-6-00

BOONE MEMORIAL HOSPITAL MADISON, WV 25130

PATIENT NO. 645784	MEDICAL RECORD NO. 000104551	FINANCIAL TYPE BLUE CRS	RELIGION OTHER		MODE OF ARRIVAL	REGISTRATION DATE 01/23/00	TIME 13:50	REGISTERED BY EP

PATIENT

PATIENT NAME LESTER CHRISTOPHER WAYNE		AGE 28	DATE OF BIRTH [redacted]/71	SEX MALE	RACE WHITE	MARITAL STATUS MARRIED	SOCIAL SECURITY NO. [redacted]3340	
MAILING ADDRESS PO BOX 1113		COUNTY OF RESIDENCE BOONE		NOTIFY IN CASE OF EMERGENCY LESTER CHARLES (DAD)			RELATIONSHIP	
HOME ADDRESS		HOME PHONE 304-369-6657		EMERGENCY CONTACT'S ADDRESS			STATE	ZIP CODE
CITY DANVILLE	STATE WV	ZIP CODE 25053	ADMIT TYPE ELECTIVE	EMPLOYMENT D & M TRUCKING			PHONE	
FATHER'S NAME (IF MINOR)			ADMIT SOURCE EMER ROOM	MOTHER'S NAME (IF MINOR)				

GUARANTOR

GUARANTOR'S NAME LESTER CHRISTOPHER WAYNE	PATIENT'S RELATIONSHIP TO GUARANTOR SELF	EMPLOYMENT STATUS FULL TIME	EMPLOYEE I.D. NO	
GUARANTOR'S MAILING ADDRESS PO BOX 1113	GUARANTOR'S HOME PHONE 304-369-6657	EMPLOYER'S NAME D & M TRUCKING		EMPLOYER'S PHONE
GUARANTOR'S HOME ADDRESS	GUARANTOR'S SOCIAL SECURITY NO. 233-15-3340	EMPLOYER'S LOCATION: STREET, CITY, STATE, AND ZIP CODE LAUREL, WV		
GUARANTOR'S CITY DANVILLE / STATE WV / ZIP CODE 25053-1110	GUARANTOR NO. 0009467	SPOUSE INFO NAME		SOCIAL SECURITY NO.
GUARANTOR'S EMPLOYER'S NAME D & M TRUCKING	GUARANTOR'S EMPLOYER'S PHONE	ADDRESS		RES. PHONE
GUARANTOR'S EMPLOYER'S LOCATION: STREET, CITY, STATE AND ZIP CODE LAUREL, WV		EMPLOYMENT		JOB PHONE

INSURANCE

PRIMARY INS. CO. NAME PEIA/BCBS	POLICY HOLDER LESTER APRIL C	INSURED RELATION SPOUSE	POLICY NO. PPBS 23508976?	
GROUP POLICY NAME PEIA	GROUP POLICY NO. 6400000	COMMENTS		
SECONDARY INS. CO. NAME	POLICY HOLDER	INSURED RELATION	POLICY NO.	
GROUP POLICY NAME	GROUP POLICY NO.	COMMENTS		
TERTIARY INS. CO. NAME	POLICY HOLDER	INSURED		
GROUP POLICY NAME	GROUP POLICY NO.	COMMENTS		

MEDICARE NO.	MEDICAID NO.	LAST T.T.	LMP	PARITY	WT.

ALLERGIES

CHIEF COMPLAINT FLU SYMPTONS

Dr. Snyder

ER M.D. ADAMSON REX PVT M.D.

PHARMACY

IV Start Pack _____
Clear Cath _____
J-Loop _____
Pump Set (Non-Filtered) _____
Pump Set (W/Filter) _____
Pump Charge _____
Control A Flow _____
Secondary Set _____
Vented Sol Set (Micro-Drip) _____
Blood Set _____
Interlink Inj Site _____
Irrigation Cap _____
Spike Adapter _____
Y-Type Adapter Set _____
Other _____

CENTRAL SUPPLY

Pelvic Exam _____
Rectal Exam _____
Laceration (Minor) _____
Laceration (Major) _____
Urinalysis—Mid Stream, Fem. Cath, St. Cath _____
Foley Tray _____
Eye Irrigation _____
02 _____
Nebulizer Tx _____
GI or OD _____
Burn _____

Other _____

CHART COPY

500688.015.0552

BOONE MEMORIAL HOSPITAL MADISON, WV 25130

CLINIC #4

Nursing Progress Notes

CHART COPY

WT. 276 TRIAGE LEVEL III

T. 98.3 P. 72 R. 18 LMP. N/A

BP 110/78 GCS 15 PAINSCALE 0

SUBJECTIVE FINDINGS/CHIEF COMPLAINT

Pt to RHC c/o cough & feels like lungs are full of water x 1-2 days — TM

CHECK IF NEGATIVE	OBJECTIVE FINDINGS/EXAMINATION:
ROS	
DERM ☐	
GU ☐	
GI ☐	
COR ☐	
RESP ☐	
ENT ☐	
MUSC ☐	
NERV ☐	
OPHTH ☐	

TIME PHYSICIAN NOTIFIED: 2100 TIME SEEN: 1545

MD TIME OF ORDERS	MEDS	PHYSICIANS ORDERS	SITE	TIME DONE	INITIALS
1600		Bicillin 1.2 million unit IM	R [illegible]	406p	KAH

DIAGNOSTIC STUDIES:

TIME	TREATMENTS & PROCEDURES	SIGNATURE	RESPONSE
DC VS	110/72 64 16 — m.s.n.		

PROBLEM LIST:

After discharge care sheet:	[X] Yes [ ] No Time Out 420pm	
Course of Patient In Emergency Dept:	[X] Unremarkable [ ] Unimproved [ ] Expired	
Condition On Discharge	[ ] Excellent [X] Good [ ] Fair [ ] Poor	
Disposition of Case	[ ] Admitted [X] Home [ ] Transferred [ ] Other	
REFERRED TO DR.	NURSE SIGNATURE: Tonya Deniello	
DISCHARGE CONDITION	DOCTOR SIGNATURE	

DIAGNOSTIC IMPRESSION: 1) Pharyngitis

PLAN/TREATMENT:
1) Hycotuss 5ml q 4° prn #120ml R-0
2) increase fluids
3) increase sleep
4) f/u c Dr. Snyder prn

PATIENT NO	MEDICAL RECORD NO	FINANCIAL TYPE	RELIGION	MODE OF ARRIVAL	REGISTRATION DATE	TIME	REGISTER
0645984	000104551	BLUE CRS	OTHER		01/23/00	13:50	S

PATIENT NAME	AGE	DATE OF BIRTH	SEX	RACE	MARITAL STATUS	SOCIAL SECURITY NO
LESTER CHRISTOPHER WAYNE	28	[redacted]/71	MALE	WHITE	MARRIED	[redacted]-33

MAILING ADDRESS	COUNTY OF RESIDENCE	NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP
PO BOX 1113	BOONE	LESTER CHARLES (DAD)	

HOME ADDRESS	HOME PHONE	EMERGENCY CONTACT'S ADDRESS	STATE	ZIP CODE
	304-369-6657			

CITY	STATE	ZIP CODE	ADMIT TYPE	EMPLOYMENT	PHONE
DANVILLE	WV	25053	ELECTIVE	D & M TRUCKING	

FATHER'S NAME (IF MINOR)	ADMIT SOURCE	MOTHER'S NAME (IF MINOR)
	EMER ROOM	

PATIENT

500688.015.0553

[redacted] 104551
LESTER CHRISTOPHER – DI/23/00
PO BOX 1113 [redacted]-6657
[redacted]VILLE WV 25953
[redacted]3340 AGE 29 [redacted]/74
BC/BS [redacted]

RURAL HEALTH CLINIC
INITIAL HISTORY (FIRST VISIT)
PVT M.D. Snyder
SPECIALISTS

DAILY MEDICINES (SEE REVERSE)
KNOWN ALLERGIES: MEDICINE , FOODS , ETC.
NKA

LAST: TETANUS 1999 MAMOGRAM PELVIC PAP RECTAL

PARITY: G N/A P A HT 5'8" WT 276

FAMILY HISTORY maternal - asthma
paternal heart disease

PAST MEDICAL HISTORY Asthma

PAST SURGICAL HISTORY denies

SOCIAL HISTORY: ALCOHOL / TOBACCO / DRUGS (CIRCLE WHAT APPLIES) denies

HEENT:

NECK:

LUNGS:

HEART:

ABD:

EXT:

NEURO:

LAST RECTAL NORMAL?
LAST PELVIC / PAP NORMAL?
LAST MAMOGRAM NORMAL?

NURSE Tonya Granville PHYSICIAN

(1)

ALLERGIES: Denies

HOME MEDICATIONS:

MEDICATION / DOSE / ROUTE / FREQUENCY	STARTED	STOPPED
Ceftin - finished	1/13/00	

(2)

West Virginia
Workers' Compensation Fund **CLAIM REOPENING APPLICATION**

Step 1 - INJURED WORKER - Complete Section I and take this form to your doctor.
Step 2 - PHYSICIAN - Complete Section III and return this form to the injured worker for delivery to employer at time of injury, or send to the Workers' Compensation Fund at P.O. Box 3151, Charleston, WV 25332.
Step 3 - (Optional) - INJURED WORKER - Take this form to the employer for whom you worked at the time of your injury.
Step 4 - INJURED WORKER - Send completed form to Workers' Compensation Fund, P. O. Box 3151, Charleston, WV 25332. It is your responsibility to see that the Workers' Compensation Fund receives the completed form.

WC-125 6-1-

SECTION I - To be completed by the injured worker (Please print or type.)

1. Claimant's Full Name (First / Middle / Last)	2. Social Security Number	3. Date of Injury
Christopher Wayne Lester	[redacted]3340	8/10/94

Mailing Address (No. or PO Box / City / State / Zip Code)	5. Telephone Number	6. Claim Number
P.O. Box 21 Hewett WV 25108	369-1289	95000 6803

PLEASE CHECK APPROPRIATE BOX(ES).

The claimant hereby petitions the Workers' Compensation Fund to reopen the above-captioned claim for the following reason(s):

☐ A. To secure additional medical treatment as described in the Attending Physician's Report.

☐ B. To be examined for Permanent Partial Disability due to:

☐ (1) Aggravation and/or progression of condition or disability resulting from compensable injury. ☐ (2) Fact or facts pertaining to the disability or condition not previously considered by the Commissioner in prior findings.

☐ C. To secure additional Temporary Total Disability benefits due to:

☐ (1) Aggravation and/or progression of condition or disability resulting from the compensable injury.

☐ (2) Fact or facts pertaining to the disability or condition not previously considered by the Commissioner in prior findings.

Temporary Total Disability benefits are requested for the periods listed below:

From 7-19-96 To present From _____ To _____

From _____ To _____ From _____ To _____

Have you suffered any other illnesses and/or injuries since the injury upon which this claim is based? ☐ Yes ☑ No
If yes, specify the nature of the illnesses and/or injuries, the dates of the illnesses and/or injuries, and the names and addresses of the physicians who treated you. _____

Have you filed any other claims with the Workers' Compensation Fund? ☐ Yes ☑ No
If yes, list all claim numbers and/or dates of injuries. _____

Have you drawn unemployment benefits since the injury covered by this claim?
☐ Yes ☑ No If yes, for what period? From _____ To _____

Did you continue to work for the employer for whom you were working at the time of the injury? ☐ Yes ☑ No
If no, please give name and address of current employer. _____

Claimant's Signature Christopher W. Lester Date 8-7-96

SECTION II - (Optional) - To be completed by the employer for whom the claimant was working at the time of the injury covered by this claim (Please print or type.)

Although this section is optional, its completion may expedite the consideration of the petition.

Employer's Name, Address and Telephone No.	2. Do you disagree with any of the information contained in Section I or III? ☐ Yes ☐ No ☐ Undetermined If yes, explain the information with which you disagree. Be specific.
Telephone Number _____	
If claimant began missing work again on _____	4. The employer waives the ten (10)-day notice period and does not object to the Commissioner's immediately ruling on the claimant's petition. ☐ Yes ☐ No

Signature Title Date

SECTION III - To be completed by the physician in detail and a narrative report attached if necessary (Please print or type.)

1. Physician's Name and Address

J. Mark Snyder, D.O.
Carepoint Physicians
705 Madison Ave
Madison, WV 25730

2. Physician's FEIN 55-0740744

3. Physician's Telephone Number 304-369-5170

4. Were you the patient's treating physician in this claim? ☐ Yes ☒ No

5. Date of examination upon which these findings are based: 7.24.96

6. Present Diagnosis: Chronic low back pain

7. Patient's Complaints: chronic low back pain c radiation into right gluteal area and leg leg and knee weakness

8. Describe treatment rendered and part of body treated: [illegible] treatment

9. Describe in detail the patient's current physical condition including any restrictions on the patient's functional abilities. (A narrative report may be attached if indicated.)

lower back pain : worse c movement
c [illegible] pain
MAE
unable to complete rehab due to pain

10. Is further treatment necessary? ☒ Yes ☐ No If yes, list the type and extent of treatment you desire to be authorized.

pain clinic

11. Will the patient be able to continue working while undergoing treatment? ☐ Yes ☒ No

12. If this patient is unable to work at his regular job due to this injury, can he return to light duty? ☐ Yes ☒ No
If yes, indicate any work restrictions.

13. Has there been an aggravation or progression of the patient's disability since being released to resume employment or being certified as having reached maximum medical improvement? ☐ Yes ☒ No If yes, list the physical findings relating to the aggravation or progression.

14. Do the current physical findings relate to a disability or condition not previously considered? ☐ Yes ☒ No

15. If patient checked C(1) or C(2) in question 7 of Section I, please show periods of Temporary Total Disability.
From ________ To ________ From ________ To ________

16. If patient checked B(1) or B(2) in question 7 of Section I, please give your opinion of the degree of Permanent Partial Disability in terms of percentage of whole man. ________ %

17. In your opinion, is the current condition or disability a direct result of the injury or disease covered by this claim? ☒ Yes ☐ No

18. If the present diagnosis is for a disability or condition not previously considered in this claim, please attach a narrative report relating the current condition to the injury covered by this claim.

[signature] DO — Physician's Signature   8/28/96 — Date

MADISON MEDICAL GROUP
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAXED

FAX COVER SHEET

TO: W. C. - Greg Hughes

FROM: MMG Paula

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 4

DATE: 12-16-96

ADDITIONAL COMMENTS:

cnrq/01-01-96/*6 ** VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner

December 11, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21
HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [redacted]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - REQUEST FOR INFORMATION

J. MARK SNYDER, D.O., please send me the following information regarding this claim:

DR. SNYDER: PLEASE PROVIDE A DETAILED MEDICAL REPORT GIVING THE DATE THE INJECTIONS WILL BE COMPLETED, AN UPDATE ON THE CLAIMANT'S CONDITION AND YOUR FUTURE TREATMENT PLAN. PLEASE GIVE AN ESTIMATED DATE THE CLAIMANT WILL REACH MAXIMUM MEDICAL IMPROVEMENT.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
NELSON TIMOTHY W
SNYDER J MARK
BACHWITT PAUL MD

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

FOR DIVISION USE ONLY

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. 950006803 SS No. [redacted] 3340 DOI 08-10-1994
Emp. Fisk No.

2. Current Telephone No. 304-369-1289

Claimant's Name and Address
Lester, Christopher
Po Box 21
Hewett WV 25108

Employer's Name and Address
Tri-State Home Center
Danville WV Inc
Po Box 987
Spencer WV 25276

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature _____ Date _____

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 11 / 29 / 96 (Month Day Year)

2. Date of next appointment 12 / 30 / 96 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care. _____

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain. _____

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☒ Consultation ☐ Evaluation ☒ Treatment Chronic pain

4. Diagnosis (ICD9-CM) code and description
847.2

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
work hardening program

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☒ Yes ☐ No If Yes, please explain condition and how it has effected recovery.
Prolonged pain

7. Will claimant need rehabilitation services? ☐ Yes ☐ No If Yes, please specify.

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ___ / ___ / ___ Trial Return to Work 1 / 27 / 97 Full-time Work ___ / ___ / ___

10. If the claimant has reached maximum medical improvement, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.
Carepoint Physicians Inc
Robert B. Atkins MD
705 Madison Av
Madison WV 25130

FEIN

12. [signature] Physician's Signature
in the absence of J. Mark Snyder DO
11/29/96 Date

500688.015.0560

appt/01-01-96/*8 ** VEN. ..R COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner

November 8, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [redacted]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - APPOINTMENT SCHEDULED

You have been scheduled for an appointment on 12/17/96, at 11:00 A.M. with:

BACHWITT PAUL MD Phone: 304-766-6114
414 DIVISION STREET
SO CHARLESTON, WV 25309

The above named physician should provide the Division with a narrative report which outlines your medical history, diagnostic studies, physical examination, diagnosis, and prognosis. The following questions should be answered:

1. Has the claimant reached maximum medical improvement? (No additional surgical or medical intervention will change the claimant's condition.)
2. Is the claimant working? If so, in what capacity? If not, could the claimant return to a modified work assignment and with what restrictions?
3. What impairment rating is recommended, using the AMA Guide to the Evaluation of Permanent Impairment, Fourth Edition?

If the claimant has not reached maximum medical improvement, what additional diagnostic studies and/or treatment do you recommend and what benefit should be expected? (Review the WCD Treatment Guides for the diagnosis before making your recommendations.)

This exam was scheduled by the Division and all bills and related expenses should sent to us.

DR. BACHWITT: PLEASE BE ADVISED THE CLAIMANT HAS BEEN GRANTED A 10% PPD AWARD FOR THIS INJURY./DR. PAUL BACHWITT, 414 DIVISION STREET, SOUTH CHARLESTON, WV/766-6114

Failure to keep this appointment may result in the closing of your claim for benefits.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
NELSON TIMOTHY W
SNYDER J MARK
BACHWITT PAUL MD

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

work hardening program

500688.015.0561

MADISON MEDICAL GROUP
35 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Greg Hughes 926-5423

FROM: J. Mark Snyder DO

RE: Christopher Lesters

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 11/18/96

ADDITIONAL COMMENTS:

CONFIDENTIALITY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US, THANKYOU.

Faxed
2:50 Pm

CarePoint

Care Point Physicians, Inc.

Madison Medical Group
Robert Atkins, M.D.
Ron D. Stollings, M.D.
John Mark Snyder, D.O.
705 Madison Ave.
Madison, West Virginia 25130
(304) 369-5170

November 13, 1996

Workers Compensation Division
PO Box 3151
Charleston WV 25332

Christopher Lester
C/# 95000 6803
SS# [redacted] 3340
DOI 8-10-1994

To Who It MAY Concern:

Christopher W. Lester Remains under my care until his next appointment which is November 27, 1996. AT that time I will REEVALUATE his condition.

Sincerely,
J. Mark Snyder DO (PH)
J Mark Snyder DO

500688.015.0563

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

FOR DIVISION USE ONLY

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED)

1. Claim No. 95006803 SS No. [redacted]3340 DOI 8-10-94
Emp. Fisk No.

2. Current Telephone No. (304) 369-1289

Claimant's Name and Address
Christopher Wayne Lester
P.O. Box 21
Hewett WV 25108

Employer's Name and Address
Tri-State Home Center
Danville WV Inc
P.O. Box 987
Spencer WV 25276

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☒ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature Christopher W Lester Date 10-30-96

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages if Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 10 | 30 | 96 (Month Day Year)
2. Date of next appointment 11 [illegible] 96 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☒ No If Yes, please advise as to how the claimant came under your care.

B. Does claimant continue under your active care? ☒ Yes ☐ No If No, please explain.

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☒ Consultation ☐ Evaluation ☒ Treatment pain clinic

4. Diagnosis (ICD9-CM) code and description (Chron PDP
847.2

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit. work hardening

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☒ Yes ☐ No If Yes, please explain condition and how it has affected recovery.
prolonged pain

7. Will claimant need rehabilitation services? ☐ Yes ☐ No If Yes, please specify.
?

8. Is claimant temporarily and totally disabled? ☒ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work ____ Full-time Work Unknown

10. If the claimant has reached maximum medical improvement, is there; or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.
Carepoint Physician Inc
J. Mark Snyder DO
705 Madison Av
Madison WV 25130
FEIN 550740744

12. [signature]
Physician's Signature
10/7/96
Date

500688.015.0564

MADISON MEDICAL GROUP
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: WC ATT: Greg Hughes

FROM: Phyllis -

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: _____

DATE: 10-30-96

ADDITIONAL COMMENTS: _____

Julie Jarrell 10/30/96 2:20

Attending Physician's Report

Return Completed Form To:
Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

FOR DIVISION USE ONLY

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. 950006303 SS No. [redacted]5370 DOI 8-10-94
Emp. Fisk No.

2. Current Telephone No. (304) 369-1289

Claimant's Name and Address
Christopher Wayne Lester
P.O. Box 21
Hewett WV 25108

Employer's Name and Address
Tri-State Home Center
Danville WV Inc
P.O. Box 987
Spencer WV 25276

3. ***Please mark any needed changes in your address as printed above.***

4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☑ No

5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
Claimant's Signature Christopher W. Lester Date 10-30-96

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination 10 / 30 / 96 (Month Day Year)
2. Date of next appointment 11 / 27 / 96 (Month Day Year)

3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☑ No If Yes, please advise as to how the claimant came under your care.

B. Does claimant continue under your active care? ☑ Yes ☐ No If No, please explain.

C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
☑ Consultation ☐ Evaluation ☐ Treatment pain clinic

4. Diagnosis (ICD9-CM) code and description
chron PID
847.2

5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit. work hardening

6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☑ Yes ☐ No If Yes, please explain condition and how it has affected recovery.
prolonged pain

7. Will claimant need rehabilitation services? ☐ Yes ☐ No If Yes, please specify.
?

8. Is claimant temporarily and totally disabled? ☑ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.

9. Please indicate the anticipated date claimant will be able to return to:
Modified Work ____ Trial Return to Work ____ Full-time Work unknown

10. If the claimant has reached maximum medical improvement, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form WC-219a, Notice of Maximum Medical Improvement.

11. Physician's Name, Address & Telephone No.
Carepoint Physician Inc
J. Mark Snyder DO
705 Madison Ave
Madison WV 25130
FEIN 550740744

12. [signature] Physician's Signature
10/30/96 Date

500688.015.0566

auth/01-01-96/*8 VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner

October 2, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [redacted]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from CHARLESTON AREA MEDI dated 09/27/1996, is Approved.

PER THE REQUEST FROM DR. TIMOTHY W. NELSON, DATED SEPTEMBER 16, 1996, THIS LETTER WILL SERVE AS AUTHORIZATION FOR A SERIES OF THREE TRIGGER POINT INJECTIONS, THREE LUMBAR EPIDURAL STEROID
INJECTIONS AND PHARMACOTHERAPY WITH NEURONTIN. BY COPY OF THIS LETTER TO DR. NELSON AT THE CAMC PAIN MANAGEMENT CLINIC, PLEASE PROVIDE A STATUS UPDATE AFTER THIS IS COMPLETED. FAX#926-5423

Your authorization number is 196275106.
Authorized Dates are 10/01/1996 through 01/01/1997.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Director, Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
CHARLESTON AREA MEDICAL CENTER
SNYDER J MARK

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

MADISON MEDICAL GROUP
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Greg Hughes 926-5264

FROM: Phyllis & J Mark Snyder

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 10/25/96

ADDITIONAL COMMENTS:

CarePoint

Care Point Physicians, Inc.

Madison Medical Group
Robert Atkins, M.D.
Ron D. Stollings, M.D.
John Mark Snyder, D.O.
705 Madison Ave.
Madison, West Virginia 25130
(304) 369-5170

October 25, 1996

Workers' Compensation Division
4700 MacCorkle Avenue, SE
Charleston, West Virginia 25130

RE: CI# 950006803
SSN 2[redacted]3340
DOL 08/10/1994

Attn: Greg Hughes

To Whom It May Concern:

This letter is to inform you that Christopher Lester is still under my care, due to his continuing chronic back pain.

If you need any more information, please feel free to contact me at any time.

Sincerely,

J. Mark Snyder DO (PH)

J. Mark Snyder, DO

plh

10/25 10:35 AM LM's. left

Call WC 926-5264
Greg Hughes
JM Snyder 10/30

Bayer Pharmaceutical Division

Chris Lester

Cipro IV

500688.015.0569